Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

BLOOD BANK SERVICES

Billing Instructions

July 1999

Copyright Disclosure

About this publication

This publication supersedes all previous MAA Blook Bank Services Billing Instructions.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
July 1999

Received too many billing instructions?
Too few?
Address Incorrect?

Please detach, fill out and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

How Do I Become A DSHS Provider?

Call the Provider Enrollment Unit according to the first letter of your business name:

A-H	(360) 664-0300
I-O	(360) 753-4712
P-Z	(360) 753-4711

Where Do I Send Hardcopy Claims?

Division of Program Support
PO Box 9248
Olympia WA 98507-9248

How Do I Request Billing Instructions?

Check out our website:

http://maa.dshs.wa.gov

or write/call:

Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800)-562-6188

Where Do I Call If I Have Questions Regarding…

Payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations Unit
1-800-562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
1-800-562-6136

Electronic Billing?

(360) 753-0318

or write to:

Electronic Billing
PO Box 45564
Olympia, WA 98504-5564

Definitions

This section defines terms and acronyms used in these billing instructions.

Blood Bank - A health care facility that draws blood from voluntary donors, and tests, processes, stores, and distributes human blood and blood components.

Categorically Needy Program (CNP) – Federally-matched Medicaid program(s) that provide the broadest scope of medical coverage. Person may be eligible for CNP only or may also be eligible for cash benefits under the SSI (Supplemental Security Income) or TANF (Temporary Assistance for Needy Families) programs. CNP includes full scope of coverage for pregnant women and children.

Client – An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) – A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. (WAC 388-500-0005)

Core Provider Agreement – A basic contract that the Medical Assistance Administration (MAA) holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Department or DSHS – The Washington State Department of Social and Health Services. (WAC 388-500-0005)

Explanation of Benefits (EOB) – A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Fraud - An attempt to obtain benefits or payments in a greater amount than that to which a provider is entitled by means of:

(a) A willful false statement;
(b) Willful misrepresentation, or by concealment of any material facts; or
(c) A fraudulent scheme or device, including, but not limited to:
    (i) Billing for services, drugs, supplies, or equipment that were unfurnished, of lower quality, or a substitution or misrepresentation of items billed; or
    (ii) Repeated billing for purportedly covered items, which were not in fact covered.

Internal Control Number (ICN) - A 17-digit number used to identify a claim. This number appears on the Remittance and Status Report near the client's name.

Managed Care – A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary services. Managed care involves having clients enrolled:

- With, or assigned to, a primary care provider;
- With, or assigned to, a plan; or
- With an independent provider, who is responsible for arranging or delivering all contracted medical care.

(WAC 388-538-001).

Maximum Allowable – The maximum dollar amount MAA will reimburse a provider for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to persons eligible for:

- Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or
- Medically needy program as defined in WAC 388-503-0320.

(WAC 388-500-0005)

Medical Assistance Administration (MAA) – The administration within the department of social and health services authorized to administer the acute care portion of the *Title XIX* Medicaid and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) card – MAID cards are the forms DSHS uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible.

Medically Necessary – A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section "course of treatment" may include mere observation or, where appropriate, no treatment at all.
(WAC 388-500-0005)

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

a) "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
b) "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.
(WAC 388-500-0005)

Patient Identification Code (PIC) – An alphanumeric code that is assigned by MAA to each client consisting of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Program Support, Division of (DPS) – The division within the Medical Assistance Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

Provider or Provider of Service – An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Remittance and Status Report (RA) – A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration that provides detailed information concerning submitted claims and other financial transactions.

Stat Charges – Stat charges are payable when sudden unexpected event occurs which requires immediate action and is needed to manage the patient in a true emergency situation. Limited to one STAT charge per episode; not once per test.

Third Party – Any entity that is, or may be, liable to pay all or part of the medical cost of care of a medical program client. (WAC 388-500-0005)

Title XIX – The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005)

Usual and Customary Fee - The rate that may be billed to the department for a certain service or equipment.

This rate *may not exceed*:

1) The usual and customary charge that you bill the general public for the same services; or
2) If the general public is not served, the rate for the same services normally offered to other contractors.

Washington Administrative Code (WAC) Codified rules of the State of Washington.

Blood Bank Services

What services do blood banks offer?

Blood banks collect, process, store and supply blood and blood products to facilities that provide blood transfusions. The processing of blood includes all laboratory work required to prepare the product for use. Blood banks also provide blood transfusions if the client is in their facility and provide anti-hemophilic factor to hemophilic clients.

Who is eligible?

All Medicaid clients are eligible for Blood Bank Services.

Are managed care clients eligible?

Blood bank services are covered under managed care. Clients covered under managed care will have a Health Maintenance Organization (HMO) indicator in the HMO column on their MAID card. The managed care plan/provider must arrange or provide all services for a managed care client. The plan's 1-800 telephone number is located on the MAID card.

Coverage

What is covered? (WAC 388-87-045)

- MAA will pay for whole blood or blood derivatives only when they are not available to the patient from other sources.

  Limitations:

  - ✓ For clients who are covered by Medicare and Medicaid, MAA will pay up to the first three pints of blood or plasma in any spell of illness.
  - ✓ MAA will not pay for blood or blood derivatives that are donated.

- MAA will pay for the service charges necessary in handling and processing blood, plasma, or blood derivatives.

  Limitations:

  - ✓ If the patient is hospitalized, all charges must be included in the hospital's charges.
  - ✓ After-hours charges, "stat" charges, and weekend charges are not reimbursable.

- Administration of blood or blood derivatives on an outpatient basis in a hospital may be added to the total payment for outpatient service.

Billing

Billing for Blood Transfusions

- Health Care Financing Administration (HCFA) regulations require blood banks to bill the outpatient provider performing a blood transfusion for the blood product processing charge.
- Under Medicaid fee-for-service (FFS), the outpatient provider performing the transfusion must bill MAA for each unit of blood. The relevant blood product procedure codes and the current maximum allowable fees are listed in the fee schedule beginning on page 9.
- The HCPCS blood codes include the collection, processing, and storage of blood. The processing includes all lab work required to prepare the product for use.
- If a blood bank also performs (staff, physician, etc) blood transfusions in its facility, bill using the P-codes on page 16.

What is the time limit for billing?

State law requires that you present your final bill to MAA for reimbursement no later than 365 days from the date of service. (RCW 74.09.160)

- **For eligible clients:** Bill MAA within 365 days **after** you provide a service(s). Delivery of a service or product does not guarantee payment.
- **For clients who are <u>not</u> eligible at the time of service, but are later found to be eligible:** Bill MAA within 365 days from the Retroactive[1] or Delayed[2] certification period.

[1] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found to be eligible for the medical services at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for these services.

[2] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

- **MAA will not pay if:**

  - ✓ The service or product is not medically necessary;
  - ✓ The service or product is not covered by MAA;
  - ✓ The client has third party coverage and the third party pays as much as, or more than, MAA allows for the service or product; or
  - ✓ MAA is not billed within the time limit indicated above.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov, or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records does MAA require me to keep in a client's file?

You must maintain legible, accurate, and complete charts and records in order to support and justify the services you provide. **Chart** means a summary of medical records on an individual patient. **Record** means dated reports supporting claims submitted to the Washington Medical Assistance Administration for medical services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service(s) provided by the practitioner must be in chronological order. For reimbursement purposes, such records must be legible; authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment, or other service to which the entry pertains; and must include, but not be limited to the following information:

1. Date(s) of service.
2. Patient's name and date of birth.
3. Name and title of person performing the service, when it is someone other than the billing practitioner.
4. Chief complaint or reason for each visit.
5. Pertinent medical history.
6. Pertinent findings on examination.
7. Quantity of medications, equipment, and/or supplies prescribed or provided.
8. Description of treatment (when applicable).
9. Recommendations for additional treatments, procedures, or consultations.
10. X-rays, tests, and results.
11. Plan of treatment/care/outcome.

Charts/records must be available to DSHS or its contractor and to the U.S. Department of Health and Human Services upon request. DSHS conducts provider audits in order to determine compliance with the various rules governing its medical programs. [Being selected for an audit does not mean that your business has been predetermined to have faulty business practices.]

Notifying clients of their rights to make their own health care decisions

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Fee Schedule

Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief descriptions of CPT® procedure codes. To view the entire description, please refer to your current CPT book.

Radiology and Laboratory Services

Procedure Code/ Modifier	Brief Description	7/1/05 Maximum Allowable Fee
36415	Drawing blood	$2.46
36416	Capillary blood draw	2.46
36430	Blood transfusion service	24.53
36450	Exchange transfusion service	71.08
36511	Apheresis wbc	57.91
36512	Apheresis rbc	58.14
36516	Apheresis, selective	1970.55
36522	Photopheresis	788.04
36550	Declot vascular device	15.90
38205	Harvest allogenic stem cells	50.87
38206	Harvest auto stem cells	50.87
38207	Cryopreserve stem cells	BR
38208	Thaw preserved stem cells	BR
38209	Wash harvest stem cells	BR
38210	T-cell depletion of harvest	BR
38211	Tumor cell deplete of harvest	BR
38212	Rbc depletion of harvest	BR
38213	Platelet deplete of harvest	BR
38214	Volume deplete of harvest	BR
38215	Harvest stem cell concentrate	BR
78120	Red cell mass, single	49.28
78120-26	Red cell mass, single	7.27
78120-TC	Red cell mass, single	42.01
78121	Red cell mass, multiple	79.94
78121-26	Red cell mass, multiple	9.99

BR (*By Report)* – Services with a **BR** (by report) indicator with billed charges of $1,100 or greater require a detailed report for payment purposes. You must attach the report to your claim. **DO NOT** attach a report to your claim for services with a BR indicator with billed charges under $1,100 unless requested by MAA.

NC – Not Covered

Procedure Code/ Modifier	Brief Description	7/1/05 Maximum Allowable Fee
78121-TC	Red cell mass, multiple	$69.72
82143	Amniotic fluid scan	7.88
82247	Bilirubin, total	5.29
82248	Bilirubin, direct	5.29
82668	Assay of erythropoietin	21.53
82784	Assay of gammablobulin igm	10.65
82803	Blood gases: pH, pO2 & pCO2	13.96
83020	Hemoglobin eletrophoresis	11.20
83020-26	Hemoglobin electrophoresis	12.04
83030	Fetal hemoglobin, chemical	9.48
83890	Molecule isolate	4.59
83892	Molecular diagnostics	4.59
83894	Molecular gel electrophoresis	4.59
83896	Molecular diagnostics	4.59
83898	Molecular nucleic amplification	19.20
83912	Genetic examination	4.59
83912-26	Genetic examinations	11.36
84460	Alanine amino (ALT) (SGPT)	6.07
85002	Bleeding time test	5.16
85013	Hematocrit	2.71
85014	Hematocrit	2.71
85018	Hemoglobin	2.71
85032	Manual cell count, each	4.93
85049	Automated platelet count	5.12
85130	Chromogenic substrate assay	13.63
85210	Blood clot factor II test	7.04
85220	Blood clot factor V test	18.66
85230	Blood clot factor VII test	15.98
85240	Blood clot factor VIII test	20.52
85245	Blood clot factor VIII test	26.29
85246	Blood clot factor VIII test	26.29
85247	Blood clot factor VII test	26.29
85250	Blood clot factor IX test	18.66
85260	Blood clot factor X test	20.52
85270	Blood clot factor XI test	18.66
85280	Blood clot factor XII test	22.17

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NC – Not Covered

Procedure Code/ Modifier	Brief Description	7/1/05 Maximum Allowable Fee
85290	Blood clot factor XIII test	$18.66
85291	Blood clot factor XII test	10.18
85292	Blood clot factor assay	21.70
85293	Blood clot factor assay	21.70
85300	Antithrombin III test	13.57
85301	Antithrombin III test	12.39
85302	Blood clot inhibitor antigen	13.78
85303	Blood clot inhibitor test, protein C	15.84
85305	Blood clot inhibitor assay, protein S	13.28
85306	Blood clot inhibitor test, protein S	17.56
85307	Assay activated protein c	17.56
85335	Iron stain, blood cells	14.75
85362	Fibrin degradation products	7.89
85366	Fibrinogen test	9.86
85370	Fibrinogen test	13.01
85378	Fibrin degradation	8.18
85384	Fibrinogen	9.21
85385	Fribrinogen	9.21
85410	Fibrinolytic antiplasminogen	8.83
85420	Fibrinolytic plasminogen	7.49
85421	Fibrinolytic plasminogen	11.67
85460	Hemoglobin, fetal	2.87
85461	Hemoglobin, fetal	7.59
85475	Hemolysin	9.91
85520	Heparin assay	15.00
85576	Blood platelet aggregation	24.61
85576-26	Blood platelet aggregation	12.26
85597	Platelet neutralization	20.60
85610	Prothrombin time	4.50
85635	Reptilase test	10.02
85660	RBC sickle cell test	6.32
85670	Thrombin time, plasma	6.62
85705	Thromboplastin inhibition	10.81
85730	Thromboplastin time, partial	6.66
85732	Thromboplastin time, partial	7.41
85999	Unlisted hematology procedure	BR

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NC – Not Covered

Procedure Code/ Modifier	Brief Description	7/1/05 Maximum Allowable Fee
86021	WBC antibody identification	$17.24
86022	Platelet antibodies	17.20
86023	Immunoglobulin assay	14.27
86078	Physician blood bank service	32.70
86317	Immunoassay, infectious agent	15.58
86329	Immunodiffusion	16.09
86592	Blood serology, qualitative	4.89
86593	Blood serology, quantitative	5.05
86644	CMV antibody	15.07
86645	CMV antibody, IgM	19.30
86687	HTLV-I antibody	9.61
86688	HTLV-II antibody	16.05
86689	HTLV/HIV confirmatory test	22.18
86701	HIV-1	10.18
86702	HIV-2	15.48
86703	HIV-1/HIV-2, single assay	15.72
86704	Hep B core antibody, total	13.81
86705	Hep B core antibody, IgM	13.48
86706	Hep B surface antibody	12.31
86793	Yersinia antibody	15.11
86803	Hep C ab test	16.35
86804	Hep C ab test, confirm	17.74
86805	Lymphocytotoxicity assay	24.69
86807	Cytotoxic antibody screening	23.94
86821	Lymphocyte culture, mixed	64.68
86849	Immunology procedure	BR
86850	RBC antibody screen	7.96
86860	RBC antibody elution	BR
86870	RBC antibody identification	BR
86880	Coombs test	6.15
86885	Coombs test	6.55
86886	Coombs test	5.93
86890	Autologous blood process	113.15
86891	Autologous blood, op salvage	BR
86900	Blood typing, ABO	3.42
86901	Blood typing, Rh (D)	3.42

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NC – Not Covered

Procedure Code	Brief Description	1/1/06 Maximum Allowable Fee
86903	Blood typing, antigen screen	10.82
86904	Blood typing, patient serum	10.89
86905	Blood typing, RBC antigens	4.00
86906	Blood typing, Rh phenotype	8.52
86920	Compatibility test	BR
86921	Compatibility test	BR
86922	Compatibility test	BR
86923	Compatibility test	BR
86927	Plasma, fresh frozen	BR
86930	Frozen blood prep	BR
86931	Frozen blood thaw	BR
86932	Frozen blood freeze/thaw	BR
86940	Hemolysins/agglutinins, auto	9.40
86941	Hemolysins/agglutinins	13.87
86945	Blood product/irradiation	BR
86950	Leukacyte transfusion	3.70
86960	Volume reduction, each unit	BR
86965	Pooling blood platelets	BR
86970	RBC pretreatment	BR
86971	RBC pretreatment	BR
86972	RBC pretreatment	BR
86975	RBC pretreatment, serum	BR
86976	RBC pretreatment, serum	BR
86977	RBC pretreatment, serum	BR
86978	RBC pretreatment, serum	BR
86985	Split blood or products	BR
86999	Transfusion procedure	13.12
87340	Hepatitis B surface ag, eia	11.83
87390	HIV-1 ag, eia	20.21
87391	HIV-2 ag, eia	20.21
87449	Ag detect nos, eia, mult	13.74
88240	Cell cryopreserve/storage	NC
88241	Frozen cell preparation	NC

BR (*By Report)* – Services with a **BR** (by report) indicator with billed charges of $1,100 or greater require a detailed report for payment purposes. You must attach the report to your claim. **DO NOT** attach a report to your claim for services with a BR indicator with billed charges under $1,100 unless requested by MAA.

NC – Not Covered

Immune Globulins and Immunizations

Procedure Code	Brief Description	1/1/06 Maximum Allowable Fee
90281	Human Ig, IM	NC
90283	Human Ig, IV	NC
90287	Botulinum antitoxin	NC
90288	Botulism Ig, IV	NC
90291	CMV Ig, IV	NC
90296	Diphtheria antitoxin	NC
90371	Hep B Ig, IM	118.24
90375	Rabies Ig, IM/SC	64.90
90376	Rabies Ig, heat treated	68.91
90378	RSV Ig, IM, 50mg	621.18
90379	RSV Ig, IV	NC
90384	Rh Ig, full-dose, IM	NC
90385	Rh Ig, mini-dose, IM	NC
90386	Rh Ig, IV	NC
90389	Tetanus Ig, IM	NC
90393	Vaccinia Ig, IM	NC
90396	Varicella-zoster Ig, IM	110.41
90399	Immune globulin	NC
90760	IV infusion, hydration, initial, up to 1 hour	38.15
90761	IV infusion, hydration, ea additional hour, up to 8 hrs	12.04
90765	IV infusion, for therapy, prophylaxis, or diagnosis, initial, up to 1 hour	46.78
90766	IV infusion, for therapy, prophylaxis, or diagnosis, ea additional hour, up to 8 hours	15.44
90767	Additional sequential IV infusion, for therapy, prophylaxis, or diagnosis, up to 1 hour	25.66
90768	Concurrent IV infusion, for therapy, prophylaxis, or diagnosis	14.76
90772	Injection, SC/IM	11.13
90773	Injection, intra-arterial	11.58
90774	Injection, IV, single or initial substance/drug	34.97
~~90780~~	~~IV infusion therapy, 1 hour~~ ***deleted 1/1/06*** (see 90760 and 90765)	~~54.73~~

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NC – Not Covered

Procedure Code	Brief Description	1/1/06 Maximum Allowable Fee
~~90781~~	~~IV infusion, additional hour~~ ***deleted 1/1/06*** (see 90761 and 90766-90768)	~~15.22~~
~~90782~~	~~Injection, SC/IM~~ ***deleted 1/1/06*** (see 90772)	~~11.36~~
~~90783~~	~~Injection, intra-arterial~~ ***deleted 1/1/06*** (see 90773)	~~11.36~~
~~90784~~	Injection, IV ***deleted 1/1/06*** (see 90774)	~~23.16~~
99001	Specimen handling	Bundled
99090	Computer data analysis	Bundled
99195	Phlebotomy	23.39

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NC – Not Covered

Injectable Drugs and Anti-Hemophilic Factors

Procedure Code/ Modifier	Brief Description	7/1/05 Maximum Allowable Fee
J0850	Injection, cytomegalovirus immune globulin intravenous (human), per vial	$672.53
J1460	Injection, gamma globulin, intramuscular, 1 cc	9.99
J1470	Injection, gamma globulin, intramuscular, 2 cc	19.97
J1480	Injection, gamma globulin, intramuscular, 3 cc	29.95
J1490	Injection, gamma globulin, intramuscular, 4 cc	39.95
J1500	Injection, gamma globulin, intramuscular, 5 cc	49.93
J1510	Injection, gamma globulin, intramuscular, 6 cc	59.95
J1520	Injection, gamma globulin, intramuscular, 7 cc	69.85
J1530	Injection, gamma globulin, intramuscular, 8 cc	79.89
J1540	Injection, gamma globulin, intramuscular, 9 cc	89.93
J1550	Injection, gamma globulin, intramuscular, 10 cc	99.86
J1560	Injection, gamma globulin, intramuscular, over 10 cc	99.76
J1563	IV immune globulin	42.04
J1564	Immune globulin 10 mg	0.42
J1565	Injection, respiratory syncytial virus immune globulin, intravenous, 50 mg (**Respigam only**)	16.18
J1670	Injection, tetanus immune globulin, human, up to 250 units	80.39
J2597	Inj desmopressin acetate	3.12
J2790	Injection, Rho D immune globulin, human, one dose package	93.54
J2792	Injection, Rho D immune globulin, intravenous, human solvent detergent	10.01
J7190	Factor VIII	0.65
J7191	Factor VIII (porcine)	1.86
J7192	Factor VIII recombinant	1.06
J7193	Factor IX non-recombinant	0.88
J7194	Factor IX complex	0.70
J7195	Factor IX recombinant	0.98
J7197	Antithrombin III injection	1.54
J7198	Anti-inhibitor	1.30
Q0187	Factor VIIA (coagulation factor, recombinant) per 1.2 mg	$1,227.51

BR (*By Report)* – Services with a **BR** (by report) indicator with billed charges of $1,100 or greater require a detailed report for payment purposes. You must attach the report to your claim. **DO NOT** attach a report to your claim for services with a BR indicator with billed charges under $1,100 unless requested by MAA.

NC – Not Covered

Injectable Drugs and Anti-Hemophilic Factors

Procedure Code/ Modifier	Brief Description	1/1/06 Maximum Allowable Fee
J0850	Injection, cytomegalovirus immune globulin intravenous (human), per vial	$721.41
J1460	Injection, gamma globulin, intramuscular, 1 cc	11.63
J1470	Injection, gamma globulin, intramuscular, 2 cc	23.27
J1480	Injection, gamma globulin, intramuscular, 3 cc	34.88
J1490	Injection, gamma globulin, intramuscular, 4 cc	46.53
J1500	Injection, gamma globulin, intramuscular, 5 cc	58.16
J1510	Injection, gamma globulin, intramuscular, 6 cc	69.86
J1520	Injection, gamma globulin, intramuscular, 7 cc	81.35
J1530	Injection, gamma globulin, intramuscular, 8 cc	93. 06
J1540	Injection, gamma globulin, intramuscular, 9 cc	104.80
J1550	Injection, gamma globulin, intramuscular, 10 cc	166.33
J1560	Injection, gamma globulin, intramuscular, over 10 cc	116.25
~~J1563~~	~~IV immune globulin~~ ***deleted 1/1/06*** (see J1566-J1567)	~~42.04~~
~~J1564~~	~~Immune globulin 10 mg~~ ***deleted 1/1/06*** (see J1566-J1567)	~~0.42~~
J1565	Injection, respiratory syncytial virus immune globulin, intravenous, 50 mg (**Respigam only**)	16.18
J1566	Immune globulin, powder	22.22
J1567	Immune globulin, liquid	28.36
J1670	Injection, tetanus immune globulin, human, up to 250 units	90.80
J2597	Inj desmopressin acetate	2.58
J2790	Injection, Rho D immune globulin, human, one dose package	88.40
J2792	Injection, Rho D immune globulin, intravenous, human solvent detergent	13.66
J7188	Injection, Vonwillebrand factor, IU	0.87
J7189	Factor VIIA, per mcg	1.04
J7190	Factor VIII	0.66
J7191	Factor VIII (porcine)	1.86
J7192	Factor VIII recombinant	1.06
J7193	Factor IX non-recombinant	0.89

BR (*By Report)* – Services with a **BR** (by report) indicator with billed charges of $1,100 or greater require a detailed report for payment purposes. You must attach the report to your claim. **DO NOT** attach a report to your claim for services with a BR indicator with billed charges under $1,100 unless requested by MAA.

NC – Not Covered

Procedure Code/ Modifier	Brief Description	1/1/06 Maximum Allowable Fee
J7194	Factor IX complex	0.68
J7195	Factor IX recombinant	0.99
J7197	Antithrombin III injection	1.66
J7198	Anti-inhibitor	1.30
~~Q0187~~	~~Factor VIIA (coagulation factor, recombinant) per 1.2 mg~~ ***deleted 1/1/06*** (see J7189)	~~$1,227.51~~
~~Q2022~~	~~VonWillebrandFactrCmplxperIU~~ ***deleted 1/1/06*** (see J7188)	~~0.87~~
~~Q9941~~	~~IV immune globulin lyophil 1G~~ ***deleted 1/1/06*** (see J1566)	~~42.04~~
~~Q9942~~	~~IV immune globulin lyophil 10 mg~~ ***deleted 1/1/06*** (see J1566)	~~0.42~~
~~Q9943~~	~~IV immune globulin non-lyophil 1G~~ ***deleted 1/1/06*** (see J1567)	~~55.93~~
~~Q9944~~	~~IV immune globulin non-lyophil 10mg~~ ***deleted 1/1/06*** (see J1567)	~~0.56~~
J3490	Unclassified Drug	Acquisition Cost

☞ **Note**: Claims billed with unlisted drug code J3490 ***must*** include the National Drug Code (NDC), the strength, and the dosage of the drug given, in the Comments section of the HCFA-1500 claim form.

BR (*By Report)* – Services with a **BR** (by report) indicator with billed charges of $1,100 or greater require a detailed report for payment purposes. You must attach the report to your claim. **DO NOT** attach a report to your claim for services with a BR indicator with billed charges under $1,100 unless requested by MAA.

NC – Not Covered

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide. A number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

Field Description/Instructions

1a. **Insured's I.D. NO.**: **Required**. Enter the Medicaid Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the medical assistance ID card (MAID). This information is obtained from the client's current monthly MAID card and consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d) An alpha or numeric character (tiebreaker).

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

2. **Patient's Name**: **Required**. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: **Required**. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, federal health insurance benefits, military and veteran's benefits) list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: **Required**. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. If the client has insurance secondary to the insurance listed in *field 11*, enter it here. When applicable, show the last name, first name, and middle initial of the insured if it is *different from* the name shown in *field 4*. Otherwise, enter the word *Same*.

9A. Enter the other insured's policy or group number *and* his/her Social Security Number.

9B. Enter the other insured's date of birth.

9C. Enter the other insured's employer's name or school name.

9D. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc. are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: **Required**. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11A. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11B. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11C. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11D. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a. - d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d** is left blank, the claim may be processed and denied in error.

19. **Reserved for Local Use**: When applicable, enter indicator **B** t indicate Baby on Parent's PIC. If the client is one of twin or triplets, enter the **B** and indicate the client on the claim as "twin A or B" or "triplet A, B, or C," as appropriate.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1,2,3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

24. **Enter only ONE (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 form.**

24A. **Date(s) of Service**: **Required**. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 04, 1999 = 070499).
Do not use slashes, dashes, or hyphens to separate month, day, year (MMDDYY).

24B. **Place of Service**: **Required**. The following is the only appropriate code(s) for Washington State Medicaid:

Code Number	To Be Used For
3	Office or center
9	Other

24C. **Type of Service**: **Required**. Enter a **3** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: **Required**. Enter the appropriate procedure code for the services being billed.

24E. **Diagnosis Code**: **Required**. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM or V58.2.

24F. **$ Charges**: **Required**. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field.

24G. **Days or Units**: **Required**. Enter the total number of days or units for each line. These figures must be whole units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Control Number.*

28. **Total Charge**: **Required**. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or patient paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: **Required**. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: **Required**. Put the name, address, and telephone # on all claim forms.

Group: Enter the group number assigned by MAA. This is the seven-digit number identifying the entity (i.e., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

Blood Bank Services

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): PJ090824LONG B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LONG, PETE J.

3. PATIENT'S BIRTH DATE MM DD YY: 09 08 24 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 62 SOUTH STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V58.2
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	04	15	00	04	15	00	3	3	86880		V58.2	500	1				
2	04	15	00	04	15	00	3	3	86900		V58.2	300	1				
3	04	15	00	04	15	00	3	3	86901		v58.2	400	1				
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. $ TOTAL CHARGE: 1200

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 1200

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

BLOOD BANK 360-222-1111
123 8TH STREET
ANYTOWN WA 98500

PIN# GRP# 2777700

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500